Application for Qualification in Dental Radiography

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687;
Ph. (515) 281-5157; http://www.dentalboard.iowa.gov

Please read the instructions on page 3 prior to completing this application. Please type or print in ink. Include the ***non-refundable*** application fee of **$40** with this application.

1. Identifying Information

Full Legal Name: (First, Middle, Last)					
Other Last Names Used: (e.g. Maiden, or other married names)			Email Address:		
Home Address:					
City:	County:		State:		Zip Code:
Work Address:					Work Email:
City:	County:		State:		Zip Code:
Home Phone:	Home Fax:		Work Phone:		Work Fax:
Social Security Number:	**Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.				
Height:	Weight:		Hair Color:		Eye Color:
Identifying Marks:	Gender: Female: ☐ Male: ☐	U.S. Citizen: Yes ☐ No ☐	If no, Visa Type or Alien Registration Number:		
Date of Birth:	City of Birth:		State of Birth:		Country of Birth:
Father's Full Name:			Mother's Full Name:		
Full Name & Address of Nearest Relative Not Living With You:					Phone:

Name of High School:	City:	State:	From: (Mo, Yr)	To: (Mo, Yr)	Diploma ☐ GED ☐
Name of College:	City:	State:	From: (Mo, Yr)	To: (Mo, Yr)	Type of Degree:
Name of College:	City:	State:	From: (Mo, Yr)	To: (Mo, Yr)	Type of Degree:

2. Training Profile

YES **NO**

☐ ☐ A. Are you a graduate of a Board-approved school of dental assisting. Year Graduated: _____

☐ ☐ B. Did you complete a formal course of study in dental radiography through a Board-approved program in the last two years or did you obtain clinical training in dental radiography while on trainee status during the last two years? If yes, attach proof of course completion or provide trainee number. See instructions. Trainee Number: _____

☐ ☐ C. Are you currently licensed by the Iowa Board of Nursing? License Number: _____
Attach proof of current licensure.

☐ ☐ D. Have you successfully completed a written examination for Qualification in Dental Radiography? (Please note instruction #3 on page 3.) Date of Exam _____ Location: _____

Office Use:	Qualification #:	Date Issued:	Fee:	Exam:	Course:

Name of Applicant _____

3. Definitions

Important! Read these definitions before completing the following questions.

"Medical Condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical Substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past (2) two years.

"Improper use of drugs or other chemical substances" means ALL of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, or use of any chemical substance prohibited by law.

SECTION 4. In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 14, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

YES	NO	
☐	☐	1. Do you currently have a medical condition which in any way impairs or limits your ability to practice dental radiography with reasonable skill and safety?
☐	☐	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
☐	☐	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dental radiography with reasonable skill and safety?
☐	☐	4. Are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
☐	☐	5. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?
☐	☐	6. Have you ever been terminated or requested to withdraw from any dental assisting school or training program?
☐	☐	7. Have you ever received a warning, reprimand, or been placed on probation during a dental assisting training program or school?
☐	☐	8. Have you ever been denied a certificate/registration to practice dental radiography or dental assisting?
☐	☐	9. Have you ever voluntarily surrendered a certificate/registration issued to you by any professional licensing agency?
☐	☐	10. If yes, was disciplinary action pending against you, or were you under investigation by a licensing agency at the time the voluntary surrender of certificate/registration was tendered?
☐	☐	11. Have any judgments been entered against you resulting from your practice of dental radiography?
☐	☐	12. Are charges or an investigation currently pending relative to your dental radiography or dental assisting certificate/registration in any other state?
☐	☐	13. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a certificate/registration you held?
☐	☐	14. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency or any jurisdiction of the U.S. or other nation?
☐	☐	15. Do you understand that if a qualification is granted by this Board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the qualification?

Name of Applicant _____

5. AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF _____

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application. I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

If dental radiography qualification is issued to me, I understand that if I violate rules or regulations, my qualification may be revoked as provided by law. I declare under penalty of perjury that my answers and all statements made by me on this application are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my registration and/or radiography qualification.

I hereby authorize the Iowa Dental Board and/or its agents to verify any information including, but not limited to, criminal history and motor vehicle driving records. I authorize all colleges or universities, employers and law enforcement agencies to release any information concerning my background to the Iowa Dental Board for radiography qualification purposes. I do hereby release said person(s) from any and all liability that may be incurred as a result of furnishing such information. A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

Signed (full name) _____

Sworn to before me this _____ day of _____ , _____

Notary Public _____ My Commission Expires:_____

6. VERIFICATION OF TRAINING (IOWA LICENSED DENTIST)

This certifies that _____ has been under my supervision and the applicant has exhibited didactic knowledge and clinical proficiency in the area of dental radiography. Graduates of an accredited dental assistant program who make application within two years of graduation are EXEMPT from this requirement.

_____ _____
SIGNATURE OF SUPERVISING DENTIST DATE

_____ _____
PRINTED NAME OF DENTIST LICENSE #

INSTRUCTIONS

1. Applicants must complete each question on the application and return to the Board office at the address on this form. If not applicable, mark “NA.” Applications must be typewritten or printed legibly in ink.
2. The application must be notarized in section 5, Affidavit of Applicant.
3. Applicants must attach proof of successful completion of the Board radiography examination OR proof of successful completion of the Dental Assisting National Board (DANB) CDA or Dental Radiation Health & Safety examination. The Dental Assisting National Board exam is not recognized if taken prior to January 1, 1986.
4. If you were on student status in dental radiology or if you trained in dental radiology while on trainee status in the last two years, your supervising dentist must complete and sign section 6 (Verification of Training).
5. If you completed your radiology training in a formal course of study through a Board-approved program, you must attach proof of course completion with this application. The course must have been completed within the last two years. (Applicants who were on student status or trainee status in the last two years do not need this proof.)
6. If you are a nurse licensed by the Iowa Board of Nursing, be sure to attach proof of current licensure.
7. Applicants should promptly inform the Board of all address/name changes, and employment changes.
8. You must include the **non-refundable** application fee of **$40.** Make check payable to: Iowa Dental Board.